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Commentary

Is it now time to prepare psychiatry for a psychedelic future?: commentary, Breen et al

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Keywords
Psychedelic; depression; social; determinant; risk.

Response

The feature published by Professor David Nutt et al about ketamine, MDMA (midomafetamine) and 'psychedelics' seems vague about size of effects for benefit and harm.[1] There is no long-term unbiased randomised controlled trial (RCT).[1] Two of the three authors report connections to the psychedelic pharma industry with possible vested interest issues and bias. Also, amphetamines were introduced in 1937, but Nutt et al affirm that all psychiatric drugs date from the 1950s.[2] 'Urgent things should be delayed and very urgent things must be delayed' is an old saying, and in this context it could mean that rushing something through and sidestepping established pathways such as drug licensing protocols (in the absence of a genuine emergency) is imprudent and unnecessary. Promoting the 'fast-tracking' of psychedelics without standard checks and balances, under the guise of helping dying people because they lack effective treatments, is unsound. Of all agents, substances known for misuse with significant psychiatric and psychological adverse effects should have extra controls and proofs of safety. Nutt et al declare 'Usually, private sector pharmaceutical companies conduct a series of double-blind randomised clinical trials, and if these reach the required size of effect, then the medicine is eligible for a marketing authorisation (a 'licence') in a given country.' The authors overlook the requirement for specific safety data. The psychological adverse effects of 'psychedelics' are unchartered territory and beyond any previous medical experience. The unknown medical and psychological consequences and substantial neuronal connectivity change/disruption confirmed by magnetic resonance imaging must counsel caution, especially given the uncertainty about the duration and reversibility of the changes.[2–4] Most medications for human consumption require animal experiments, standard RCTs and head-to-head comparison studies with established medications with statistical power, and long-term safety and efficacy data. Ketamine, midomafetamine (MDMA) and 'psychedelics' lack these basic safety parameters.[5] They require time to administer, counselling before and after, and medical and psychiatric/psychological surveillance. They are novel agents in the medical pharmacopoeia and though intriguing from a mode-of-action point of view, do require to be tried and tested before release to the population. The opiate crisis in the USA, driven substantially by prescribing doctors, is not to be ignored.[4] Payment for all the resources required around such prescribing is an issue. The poor with severe depression cannot afford it, and those with money and resource-rich psychiatric services will be the 'beneficiaries'. Is it therefore a niche treatment for the wealthy?[6] Development of novel medications for psychiatric illness has advanced the field – for example, stimulants for attention-deficit hyperactivity disorder, lithium for bipolar disorder and clozapine for schizophrenia – so it is not a question of being unaware and afraid of developments, but of managing them safely and correctly according to well-established protocols, and limiting substance diversion and possible future class actions.[2,3]

The jury is out on MDMA as a treatment for post-traumatic stress disorder, given the retraction of three related papers and the rejection of MDMA by the Food and Drug Administration.[6] The same verdict applies to ketamine and 'psychedelics' as shown by the diverse opinion in top-tier journals.[5–8] Off-label unregulated ketamine prescribing, for example, is now a celebrity drug even touted by Elon Musk.[8,9]

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Declaration of interest

None.

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